ASSUMPTION COLLEGE HEALTH ENTRANCE FORM

Immunization Record

Name of Student

Date of Birth (mm/dd/yyyy)

In accordance with Massachusetts state law, Assumption College requires all Graduate students enrolled in 9 or more credits in a semester and all international students and Health Sciences students regardless of credit load, to submit documentation of immunity to the Graduate School. **The health care provider must complete this Immunization Record OR attach a copy of the student's immunization record on office stationery.**

Required Immunizations

	MM / DD / YYYY
Hepatitis B ■ 3 doses required for 20 mcg series ■ Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 weeks apart; at least 16 weeks between Doses 1 and 3 *OR* ■ Hepatitis B Immune Serology (titer) accepted ■ Lab documentation is attached	Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ *OR* ☐ Lab documentation is attached ☐
Varicella (Chicken Pox) ■ 2 doses of Varicella ■ Doses 1 and 2 at least 4 weeks apart *OR* ■ History of disease *OR* ■ Varicella Immune Serology (titer) accepted Lab documentation is attached	Dose 1 ____/____/____ Dose 2 ____/____/____ *OR* History of Varicella Disease (date) ____/____/____ *OR* ☐ Lab documentation is attached ☐
Meningococcal Meningitis (required for students living on campus) ■ 1 dose of MPSV4 in the last 5 years *OR* ■ 1 dose of MCV4 in the last 5 years *OR* ■ Signed waiver is attached (found on Graduate School website)	MPSV4 Menomune ____/____/____ *OR* MCV4 Menactra or Menveo ____/____/____ ____/____/____ *OR* ☐ Waiver is attached ☐
Measles, Mumps, Rubella (MMR) ■ 2 doses MMR ■ Dose 1 after 1st birthday; Dose 2 at least one month after Dose 1 *OR* ■ MMR immune Serology (titer) accepted ■ Lab documentation is attached	MMR Dose 1 ____/____/____ MMR Dose 2 ____/____/____ *OR* ☐ Lab documentation is attached ☐
Tetanus-Diphtheria and Pertussis (Tdap or Td) ■ 1 dose of Tdap within the past 10 years *OR* ■ a Td booster within the past 5 years	Tdap ____/____/____ *OR* Td ____/____/____
OTHER VACCINES (not required) **Human Papillomavirus (HPV)** ■ 3 doses Gardasil 0.5 mL ■ Doses 1 and 2 at least 1-2 months apart ■ Doses 1 and 3 at least 6 months apart **Meningitis B** ■ 3 doses Trumenba 0.5 mL ■ Doses 1 and 2 at least 2 months apart ■ Doses 1 and 3 at least 6 months apart	Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

Please return to:

Assumption College
Attn: Brenda Torres, Medical Secretary, Graduate Studies
500 Salisbury St.
Worcester, MA 01609
Phone: (508) 767-7507
Fax: (508) 767-7098

Provider Name (print) _____ Provider Signature _____ Date (mm/dd/yyyy) _____

Street Address: _____ Suite _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

ASSUMPTION COLLEGE HEALTH ENTRANCE FORM

Tuberculosis Risk Questionnaire

Name of Student

Date of Birth (mm/dd/yyyy)

Student:

1. Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? ☐ Yes ☐ No
2. In the past 5 years have you lived in or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East *for more than 1 month?* ☐ Yes ☐ No
3. In the last 2 years, have you lived or spent time with someone who has been sick with TB? ☐ Yes ☐ No
4. Do you have (or have you had) any of these medical conditions? ☐ Yes ☐ No

Cancer	**HIV infection**	**Stomach or intestine surgery**
Colitis	**Kidney disease**	
Diabetes	**Rheumatoid arthritis**	

5. Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections? ☐ Yes ☐ No
6. In the past 1 year have you injected drugs that your doctor did not prescribe? ☐ Yes ☐ No
7. Have you ever lived or worked in a prison, jail, homeless shelter, or long-term care facility? (ex. nursing home, rehab facility, substance abuse treatment) ☐ Yes ☐ No

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Health Care Provider:

If the patient answered "yes" to any of the above questions, A PPD tuberculin skin test *(Mantoux)*, OR interferon-gamma release assay IGRA *(QuantiFERON TB-Gold QFT-GIT, T-SPOT TB test* is required.) – **Please Complete Section A.**

If patient has had a positive tuberculin test in the past, the test should not be repeated. - **Go to Section B.**
A history of BCG vaccine does not exempt testing.

A. TB TEST DOCUMENTATION

Tuberculin Skin Test/ PPD: Plant date:____/_____/_____ Read date*:____/_____/_____ Result*:_____mm of induration
*48-72 hours after administration *If no induration, mark "0"

QuantiFERON TB-Gold: Performed:____/_____/_____ Interpretation: ___Positive _____Negative _____*Indeterminate
*requires repeat test or chest x-ray

T-SPOT: Performed:____/_____/_____ Interpretation: ___Positive _____Negative _____*Indeterminate
*requires repeat test or chest x-ray

B. TERTIARY SCREEING: if Tuberculin Skin Test or IGRA is POSITIVE (now or by history) the following are required:

Date of Positive PPD:_____/_____/_____

Chest X-ray (attach the report, NOT the x-ray): Normal ☐ Abnormal ☐ Date:_____/_____/_____

Describe:

Clinical Evaluation: Normal ☐ Abnormal ☐

Describe:

Treatment: Yes ☐ No ☐ Drug, dose, frequency and dates:

Health Care Provider's Name (Print):

Provider's Signature: **Date:**

Address: **Phone:** **Fax:**